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Innovations

IN CONTINUING CARE

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The role of the New Horizons Directors

A key philosophy in the development of health policies and programs in Alberta is a commitment to partnership, and collaboration with all stakeholders. The New Models in Continuing Care Demonstration Project is an example of partnership in action. It involves major stakeholder groups, including consumers, service providers, researchers and government.

The Demonstration Project arose from the fact that many seniors and lay and professional caregivers expressed dissatisfaction with traditional approaches to the provision of long term care. Clients served by the continuing care system — both facility and home-based — had many different needs and preferences. Therefore, a one-size-fits-all approach was not the most appropriate way to provide continuing care programs and services.

Seniors have said that traditional approaches to facility-based care tended to limit autonomy and independence, and in some cases even created dependence. Individuals or groups of similar clients needed to have more variety and choice of

services. Consumers are expressing a strong desire to be involved in decisions that affect their personal health and independence, and are requesting a range of service options to choose from. Demonstration projects, therefore, are not intended to replace the existing continuing care system, but instead are designed to enhance the current system and support the development of a comprehensive and co-ordinated community-based health system.

Cree; Mary Davis; Fred Engelmann; Mary Engelmann; Neli Jackshaw; Mary Norman; Kenneth C. Pals; and Corinne Schalm.

Many of the New Horizons Directors have served with the Seniors Advisory Council for Alberta. The Seniors Advisory Council has long been interested in a new approach to the provision of continuing care — one that provides greater opportunities for choice and control on the part of the service recipients. The Demonstration Project directors have a great deal of experience in contributing to the Alberta community, especially work on senior's issues and services.

The Directors

The New Models in Continuing Care Demonstration Project is funded by Health Canada's New Horizons Partners in Aging Program. New Horizons is a unique program initiated in 1972 for the benefit of older and retired Canadians. It is a federal program administered by Health Canada, and is designed to enhance health promotion and illness, injury/crisis prevention for older adults at risk. As required by Health Canada, the overall Demonstration Project is governed by a board — the New Horizons Directors: Frank Appleby; Richard Cherry; Wanda

The partnership approach

The New Models in Continuing Care Demonstration Project has been established to implement and evaluate innovative, client-centered models for delivering continuing care services. The Demonstration Project is committed to a partnership approach. Its emphasis is on demonstrating new approaches, forming new partnerships and

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The functions of the Directors

The governing Board of Directors has specific functions related to the project.

Responsibility – The board is responsible for overseeing the organization and management of the Demonstration Project. Members participate at New Horizons Directors' meetings, and review reports on workplans and communication activities.

Accountability – Members are accountable for project funds. They approve the project's budget and receive regular quarterly reports on project expenditures. Directors also complete activity and accounting reports to Health Canada, including budget reports. They ensure that Alberta seniors and the general public receive information about the project.

Vision – Board members are keepers of the values in the project vision.

Evaluation – Board members oversee the evaluation of the New Models in Continuing Care Demonstration Project. They approve the evaluation objectives, receive regular quarterly reports on the progress of the evaluation process, and approve the final report.

A philosophy of consultation with clients and caregivers to create policy change is an underpinning of the Demonstration Project.

Committee representation

Members of the New Horizons Directors are also represented on the various committees associated with the Demonstration project.

Continuing Care Outcome Measures Steering Committee – This group provides advice on long range policy and program development to Alberta Health. This is the group that sponsored the Invitation for Proposals for demonstration project sites sent to the Regional Health Authorities, the Provincial Mental Health Board, and to providers of continuing care services in March/April, 1995. New Horizons Director representatives are Mary Davis and Mary Norman.

Consultation Group – A philosophy of consultation with clients and caregivers to create policy change is an underpinning of the Demonstration Project. Therefore, the Consultation Group exists to ensure information sharing, peer support, and consultation regarding project implementation. Representatives from each of the twelve project sites participate as members of this committee. The group also collaboratively reviews

progress. New Horizons Director representatives are Richard Cherry, Frank Appleby, and Neli Jackshaw.

Evaluating Innovative Programs in Continuing Care (EPICC) – Those of you familiar with this newsletter will have followed the regular EPICC inserts. Funded by the Seniors Independence Research Program (SIRP) of Health Canada and being carried out by a formal research team at the University of Alberta, EPICC is evaluating five of the twelve projects that are a part of the New Models in Continuing Care Demonstration project. EPICC's focus is theory development and research to improve practice. The EPICC Project is now part of each quarterly New Horizons Directors meeting, and the Directors play a valuable role in critiquing various parts of the research project, consistent with the role as "keeper of the values in the project vision." Two of the New Horizons Directors are actively involved in the Quality of Life work group that is developing methods to document residents' experiences in these new approaches in terms of choice, independence, autonomy and quality of life.

Integrated care supports independent living

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Two integrated community care programs are participating in the New Models in Continuing Care Demonstration Project. Such programs are designed to co-ordinate and provide a full range of services to help the frail elderly remain in their homes and communities.

The programs are the Capital Health Authority's (Edmonton) Comprehensive Option of Integrated Care for the Elderly (CHOICE) and the Cold Lake Health Centre's Maximum Access - Continuing Care Services.

As well as co-ordinating services for the frail elderly to support independence, integrated care programs aim to prevent early admissions to facilities, and provide family caregivers with assistance and respite. Key in the success of integrated care programs is the concept of partnerships: partnerships between caregivers, family members and, of course, clients. The commitment to partnerships permits the appropriate distribution of responsibilities.

The Capital Health Authority offers CHOICE

Modeled after a successful U.S. program, the Capital

Health Authority's CHOICE project is aimed at seniors who may otherwise be eligible for admission into a continuing care facility or who are frequent users of acute care. CHOICE combines medical, social, and supportive services to provide a full continuum of care to older people whose health needs are many and complex. The program is unique in that it is the first Canadian replication of the Program of All-Inclusive Care for the Elderly (PACE) model started in California, which now exists in 15 cities and 12 U.S. States.

CHOICE offers a day program and health clinic operating five days a week. Home services are available every day and emergency help responds 24 hours per day. CHOICE is currently offered out of the Good Samaritan Mount Pleasant site and the Capital Care Dickensfield Site. A third site at Capital Care Norwood will open in late 1996.

Demonstration Project Coordinator Bruce Finlayson says that the program helps maintain seniors at home and reduces the use of acute care and continuing care facilities. "CHOICE offers a better way to manage functional deterioration and addresses social isolation," he explains. "And it permits

detection and management of health problems, which is important given the growing numbers of seniors in the Edmonton region."

CHOICE has had a successful beginning. There are currently 120 participants in the two programs. The speed of implementation and the changing health care environment presented implementation challenges; however, the site teams have worked very well to meet these challenges.

The program is designed to serve four types of clients: Alzheimer clients; the functionally frail; the medically fragile; and those with dementia. Almost all of these people are at risk of institutional admission and may be frequent users of acute care services. Some of the clients have poor or strained support systems.

The services are provided and managed by an interdisciplinary team of health professionals and caregivers. The program consists of three

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Integrated care

... continued from panel 3

core elements which provide the following comprehensive services:

Day centre services

- social activities
- personal care and grooming
- teaching and health promotion
- maintenance and restorative rehabilitation
- meal service
- personal and family support

Home-based services

- assistance with personal care
- aides and adaptations at home
- homemaking services
- meal service
- emergency response system

Primary health care services

- physicians assessment, treatment, monitoring
- medical management in acute care
- assessment and treatments
- medical consultation
- dentistry
- optometry
- podiatry
- dietitian.

As well as providing managed care to seniors and allowing clients to maintain independence, the program offers significant costs savings to the health care system. The PACE experience in the United States resulted in

savings of between five and 25 per cent, and most of the savings were realized from a reduction in acute care utilization. With PACE, 84 per cent of the clients were able to live independently by using managed care services. A two-year evaluation of the CHOICE has just been initiated.

Information about this demonstration project, including implementation recommendations, factors that are critical in making the program work, and indicators of success, can be obtained by contacting: Betty Anne Christie, Project Director, Capital Health Authority, Community Care and Public Health, CHOICE Program, 10243 - 178 Street, Edmonton, Alberta T5S 1M3. Phone (403) 496-2545; fax (403) 496-2568.

Cold Lake Health Centre – Maximum Access

Similar to the CHOICE program, the Cold Lake Health Centre's Maximum Access program aims to support people staying in their homes for as long as possible. Other goals include promoting seamless boundaries between institutional and community-based services, and support to care-

givers who are assisting people at risk who choose to live in the community.

The program is based on a partnership, and participants include the Lakeland Regional Health Authority, the Cold Lake Health Center, Home Care, the Cold Lake Lodge, Psychogeriatric Team, and the Seniors Action Group, which represents seniors in all the surrounding communities.

Staff at the Cold Lake Regional Health Centre see the Maximum Access integrated care program essentially as an enhancement of currently available services. "It is a co-ordinated plan of care between the client and family, Cold Lake Health Centre and Home Care," explains the Co-ordinator, Clinical Services. Maximum Access' primary objective is to enable the individual in the community to maintain and improve health, quality of life and personal independence by making resources of a supportive, residential setting and an array of health and personal services available to meet the needs of individuals."

Maximum Access offers some core services: physiotherapy, occupational therapy, recreation therapy, bathing program, respite bed and senior day program.

The PACE experience in the United States resulted in savings of between five and 25 per cent and most of the savings were realized from a reduction in acute care utilization.

EPICC: Partnerships in service delivery

Residents are partners deciding what services they will receive, and how and when they will receive these.

The provision of health care for an aging population has become a key policy issue of the 1990s. According to Norah Keating, EPICC service delivery team leader, "there is a new policy paradigm of care to frail seniors. Its basic assumption is that there are caring partnerships in which residents, family, and friends collaborate with a variety of paid workers to provide the array of services required by a resident". The new paradigm appears to reflect current values of empowering seniors. Residents are partners and primary decision makers regarding their care.

Policies are being rewritten on the assumption of these caring partnerships, yet constraints on each of the partners are evident. There has been a reduction in formal support for older Canadians. Although, families and friends already provide extensive support to seniors, current trends such as the increased participation of women in the paid labour force, are likely to further reduce the capacity of the informal system to provide support. The rapid growth of the oldest segment of the elderly population means that seniors in continuing care programs are older and tend to have higher care needs. Given these trends, it is not clear whether caring partnerships can work.

Each of the programs participating in EPICC has a 'partnerships' philosophy. This gives us an opportunity to

determine how caring partnerships are working. For each continuing care resident, we will be gathering information on elder care tasks done by each of the partners, including paid staff, family members, friends, and volunteers. We will also survey the partners' beliefs about responsibilities for elder care.

Partnerships in Process

EPICC involves an approach to evaluation that involves collaboration with stakeholders throughout the research process. There is an ongoing exchange of information between research team members, site representatives, and multiple stakeholders in all research theme areas. (see figure below). We have had valuable contributions in the development of our service delivery methods and instruments from site representatives; the New Horizons Directors, (see cover story); and direct service providers from three of our sites. Site representatives collaborated to develop a list of elder care tasks. This list of definitions has continually

been revised based on feedback from the New Horizon Directors and direct service providers. Dr. Janet Fast, a family and consumer economist, consulted with us on methods to track caregiving partners' use of time in providing services to residents.

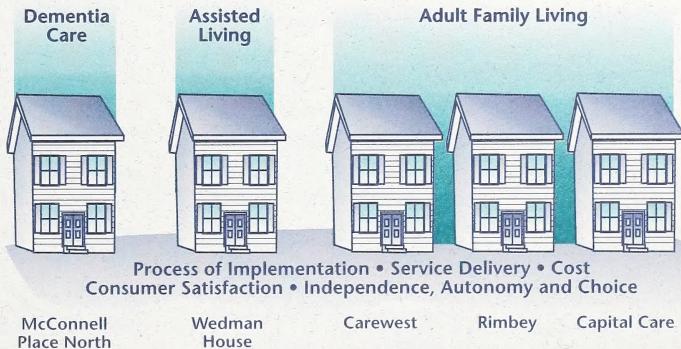
Studying Partnerships in Practice

EPICC is using two methods to address the nature of caring partnerships:

1. time-use diaries to collect information on the elder care services provided by family members, friends, volunteers and direct service providers, and
2. a questionnaire to collect information on the beliefs of residents, family members and direct service providers about who should provide what elder care tasks.

The first method is to track all services provided by partners to each resident in each model of care. "You want to know something about the way in which responsibility for care is shared amongst partners in caring arrangements and one

The EPICC Evaluation



EPICC: Partnerships in service delivery

way to understand them is to understand the relative amounts of time different partners are spending providing assistance or services to residents. Time-use is really about how people spend their time, not just the kinds of things people do, but how much time they spend doing them," says Dr. Fast.

In EPICC, four methods of time-use data collection were selected and pilot tested at three EPICC sites. Two direct service providers from each site participated in the pilot. Teresa O'Riordan, EPICC Research Associate, states that "the direct service providers have contributed time and insight into the time-use methods piloted." We appreciate the valuable feedback on the research methods and instruments that was provided by Kerry Kilback and Sandra Podloski, resident companions from McConnell Place North, Eman Gaudet and Laura Wheeler, home operators from the Family Home Program, and Jannet Brown and Claudia Cabrera, assisted living workers from Wedman House. "The challenge for EPICC is to select a combination of methods that is most accurate and least intrusive to all partners and accommodates the intensity of time spent with residents by the partners," says Dr. Keating. The pilot with direct service providers was completed in August 1996; the pilot with family members and residents will occur in the fall of 1996.

The second method is to explore beliefs about care-giving responsibilities among the partners. We developed a questionnaire on the beliefs

about responsibility for numerous elder care tasks. This questionnaire uses the list of elder care tasks described earlier. The questionnaire was piloted with site representatives and subsequently the format of the questionnaire was revised. The questionnaire will be completed by triads of residents, family members and direct service providers in the 1996-97 fiscal year.

Service delivery outcomes

Information on the distribution of services among caring partners will provide the first comprehensive assessment of all services provided to residents. "It will give a better understanding of how responsibility for providing services to a target resident is divided among the partners, not just who's participating, but participating in what way and at what level," explains Dr. Fast. Findings from this type of partnership inquiry can address policy questions about the interface between formal and informal caregivers and the beliefs among partners regarding the limits of partners' responsibilities.

Findings may also inform us as to the magnitude of caring capacity within the formal sector, particularly as shifts from professional staff to multi-skilled workers occur. Ms. O'Riordan states that participation in the time-use pilot increased the direct service providers' self-awareness in terms of how much they do. "It's validating to some of their experiences of being very tired at the end of the day," she says. "It gives

evidence to frequent interruptions which addresses some of the mental fatigue that staff have noted, that they've got a lot of things going on in mind concurrent with actually doing things. And one task that they set out to do maybe doesn't get completed because there's a resident need that needs to be addressed immediately."

"Some direct service providers have commented that they think the information could be used to talk about discrepancies between program philosophy and what actually is happening," continues Ms. O'Riordan. "For example, in a program where there's a social interaction emphasis, in looking at their day in actual minutes, direct service providers may see that most of their time has been spent changing beds and preparing meals. They can then address the issue of not being able to provide social interaction at a level they would like.

EPICC's innovative approach to studying partnerships will have several benefits. It will help us understand how caring tasks are shared; how partners' view their own caring responsibilities; and how philosophies of care are expressed in practice.

If you have questions, please contact the project at 403-492-2865, fax 403-492-3012, or e-mail at jacquie.eales@ualberta.ca. Or you may write to: The EPICC Project, Room 343, Assiniboia Hall, University of Alberta, Edmonton, AB, T6G 2E7.

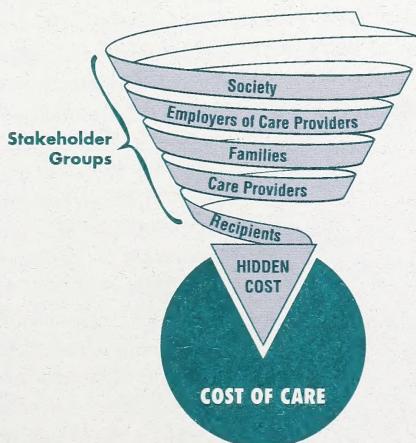
The Hidden Costs of Informal Elder Care

Informal elder care can increase costs to the elders receiving care, informal care providers, their providers' families and employers, and the taxpayer.

Community care for seniors is believed to be of better quality than institutional care. It is also believed to cost less. But community care is less costly largely because it relies more heavily on informal caregivers whose services are thought of as "free."

Researchers at the University of Alberta are finding that informal care is far from free. According to Janet Fast, principal investigator on the "Hidden Costs of Informal Elder Care"¹ project, "everyone with a stake in this issue – seniors, care providers, their families and employers, and taxpayers – experience some costs when someone takes on informal elder care responsibilities."

The Hidden Costs of Informal Elder Care – by stakeholder group



Costs to seniors

While seniors who receive informal care do benefit from the care, research shows they also suffer emotionally, experiencing feelings of:

- guilt
- loneliness
- loss of control
- helplessness
- anger

Deanna Williamson, a research associate to the project, observes that "if policymakers are to change the elder care system effectively, they need to understand the effects of informal elder care on seniors. We don't have a good feel for that yet."

Costs to informal caregivers

Family members and friends who provide elder care pay economically and emotionally through:

- out-of-pocket expenses
- lost income and employment benefits
- taking on unpaid work
- stress

Care providers spend money on goods and services they would not normally buy if they were not providing care. They may buy medication or health supplies for the seniors they look after. They might hire a housekeeper or babysitter so they can spend more time caring for the

senior. If the elder lives with them, they may have to adapt their home by building ramps or installing grab bars.

When they take on elder care responsibilities, caregivers sometimes have to quit paid jobs or work part time instead of full time. They may give up career opportunities like moves, promotions or training. This means lost income and employment benefits such as health insurance and pension plans. Giving up contact with co-workers may make them feel isolated.

Community care can only be less costly than institutional care if the work of informal caregivers on which it depends is thought of as free. The informal caregiving involved in community care depends on unpaid work and, like housekeeping and childcare, this work tends to be "invisible." Unpaid work is productive and economically valuable. Its value can be assessed.

Like the seniors receiving care, providers can suffer personal costs. They may feel guilt and anxiety, and experience declining mental and physical health. It is not uncommon for caregivers to spend less time on social and leisure activities, and on personal development, because of their caregiving responsibilities.

¹"The Hidden Costs of Informal Elder Care" project is funded by the National Health Research and Development Program of Health Canada. Research team members are Janet Fast, Norah Keating and Deanna Williamson from the University of Alberta, and Leslie Oakes from the University of New Mexico.

The Hidden Costs of Informal Elder Care

When fewer formal elder care services are available, other stakeholders must take on more of the responsibility and more of the cost.

Costs to care providers' families

Little is known about the effect that taking on elder care responsibilities has on informal caregivers' family members.

Research tends to focus on the caregivers themselves.

However, because the experiences of one family member affect all other family members, directly or indirectly, caregivers' family members are also bound to be affected by the caregivers' additional responsibilities. Some of the research available in this area indicates:

- strained and weakened family ties
- disrupted schedules
- loss of privacy
- deterioration of marital relationships

Costs to employers of care providers

When caregivers have to balance paid work and caregiving responsibilities, the cost to their employers may be:

- decreased productivity
- employee turnover
- employee assistance programs (EAPs)

When employees are tardy, absent or distracted because of their caregiving responsibilities, their productivity on the job suffers. When caregivers have to quit or change their jobs, employers' hiring and training costs go up. If, in order to retain staff, an employer has to implement EAPs, such as family responsi-

bility leave, or alternate working arrangements, such as part-time work, compressed work weeks or job-sharing combined with full benefits, the cost of doing business goes up.

Costs to taxpayers

Informal care may look less expensive to taxpayers in the short term, but a number of hidden costs are rarely factored into the usual cost-benefit analysis. Some of these costs are experienced immediately; others may be delayed, such as:

- lost tax revenue
- health care costs
- higher poverty rates
- programs for informal caregivers

When caregivers work fewer hours and sacrifice present and future income, income tax revenue is lost. Lost employee benefits, combined with the negative health effects of the demands of caregiving, increase caregivers' need for health care services. Caregivers who give up paid work can't contribute

to public or employer-sponsored pension plans. Less retirement investment means, they're more likely to end up poor seniors themselves and more dependent on the social welfare system.

Stakeholders' costs are interdependent

Costs to meet seniors' needs are shared by stakeholders. The share borne by one depends on the share borne by the others. When fewer formal elder care services are available, public expenditures on elder care may go down, but other stakeholders must take on more of the responsibility and more of the cost.

A new public policy environment is emerging that emphasizes partnerships in caregiving. In practice, this means less institutional and other formal care and more community and informal care. "If policymakers are serious about this, they're going to have to change the way they look at cost as well as responsibility," says researcher, Janet Fast. "If they want to assume shared responsibility for meeting seniors' needs, they must also acknowledge shared costs. They need to understand that when they shift responsibility from the public sector to the community, they're not reducing overall cost, they're just shifting some of the cost from the public sector to other stakeholders — to informal caregivers, their families and their employers."

If you have questions, please contact the project at 403-492-5768, fax 403-492-6345, or e-mail at janet.fast@ualberta.ca. Or you may write to: Janet Fast, Room 3-43, Assiniboia Hall, University of Alberta, Edmonton, AB, T6G 2E7.

Perspectives on Elder Care

Seniors believe that tasks that help them stay in their own homes are the most important help to maintaining independence.

One of the biggest challenges facing Canadians is the provision of good quality, cost-effective care to seniors. The challenge has become especially acute as funding of health and social services to Canadians and in particular seniors has been reduced while the numbers of seniors has grown. There is growing debate about the best strategy to meet this pressure of demography and dollars. One perspective on the debate is that families are most suited to do the majority of elder care. Another is that partnerships in caring are best and that families, the public sector and seniors themselves need to work together to provide the best care.

Understanding elder care

“The Defining Elder Care Project¹ was developed to inform the debate,” says Norah Keating, the principal investigator on the project. “The first step in understanding how to provide care was to understand what is meant when we talk about elder care. Is it personal care for frail seniors? Is it adapting a house to allow a senior to remain in the community? Is it all of the things that families do for older relatives?”

Although there was general agreement that strategies were needed to ensure seniors were taken care of, the key

stakeholders in the debate had no shared definition of the issue.

“The project was organized so that we would hear from members of a variety of stakeholders in the debate,” says Shauna-Vi Harlton, the research assistant on the project. “We wanted people who had a strong interest in the elder care debate and who represented a range of perspectives.”

Seven different groups of people who had personal and professional interests in care for seniors were involved in the study. They were seniors, family members of seniors, friends and neighbours of seniors, volunteers working with seniors, professionals working with seniors, regional and provincial policy makers and federal policy makers. Each of the seven sets of people met together in a focus group to discuss their perspectives on what is elder care. They were asked to talk about their definition of elder care, the tasks that they would include in elder care and which of those tasks were most important.



The elder care basket

Participants in the focus groups viewed elder care as a set of tasks and services that help seniors enhance or maintain their independence. From their comments, the project developed a list of elder care tasks. There was general agreement that the following are the major elder care tasks:

- personal care
- housework
- household maintenance and repair
- household renovations
- shopping for goods and services
- transportation
- management of financial affairs
- care management

This set of tasks is very broad and includes what most stakeholders thought was ideal; everything from coordinating services to the senior to practical assistance with daily activities. However, when participants were asked which tasks are most important, it was apparent that there were substantial differences in perspectives on which tasks should be in the elder care basket. Seniors argued that



¹ The Defining Elder care Project is funded by the National Health Research and Development Program of Health Canada. Researchers on the team are Norah Keating, Janet Fast and Shauna-Vi Harlton from the University of Alberta; and Leslie Oakes from the University of New Mexico.

Perspectives on Elder care



Seniors believe that relying on family members decreases their independence.

tasks that helped them stay in their own homes were the most important because they helped them to maintain their independence. Household work, home maintenance and repair were highest on their list. "Well I would imagine when it gets to the point where I can't dig my own flower beds, cut my own grass and that, I'm sure that I would hire somebody to do it. I don't have a great income either, but I'm sure I could arrange to have it done, hire somebody to do it," said one senior.

In contrast, federal policy people put personal care tasks at the top of their list. They believed that meeting these basic needs was critical to the independence of seniors. Other tasks were seen as desirable, but would need to be taken out of the elder care basket if resources were limited. "I would tend to, you know, start with the basics ... as you get up higher, yes counselling, social friendly visits and I think I would discount those quite heavily," commented a member of the federal policy focus group.

Clearly the shared definition of what is elder care began to break down when participants were asked to set priorities about the most important elder care tasks.

Who should do the caring?

Providing services to seniors was not seen as sufficient to increase their independence, regardless of what services were in the elder care basket. The source of the care—from family and friends, from paid care workers, from the public sector—was also seen as crucial. Thus personal care received from a homecare worker did not have the same effect on independence as receiving assistance with personal care from a family member.

Participants agreed that the source of assistance was important. However, they differed on whose caring was most likely to enhance independence. Seniors believed that relying on family members decreased their independence. "I think it's because sometimes the person in question feels that the family is trying to run their life, and where the suggestion comes from an outsider, it's because this person is just interested in what they're doing," another senior reported. Federal policy makers had a very different perspective. They believed that independence was enhanced if tasks were

performed by seniors and their informal caregivers. Involvement of the formal sector made people dependent. "You have to create the environment in which people can help themselves and in which families and communities can help seniors," said a policy maker.

Policy implications

In this study, seniors and those who are developing policies for seniors had a shared view of elder care only in the broadest sense. They differed in their view of tasks that would most likely help them remain as independent as possible. And they differed in their view of who should provide the tasks they needed. It is difficult to see how these two solitudes can be reconciled so that seniors are well served. The shrinking public sector involvement in elder care may seem to be reducing the cost of elder care. Yet the costs to seniors and their families have yet to be calculated.

If you have questions, please contact the project at 403-492-4191, fax 403-492-3012, or e-mail at norah.keating@ualberta.ca. Or you may write to: Norah Keating, Room 3-43, Assiniboia Hall, University of Alberta, Edmonton, AB, T6G 2E7.

In summary ...

Health Canada's partnership is a major factor in pushing their project forward. Not only was the major funding for the project provided by Health Canada, but because of the underlying efforts of Canadians, represented by these contributions, health care in Canada can be improved for

our elders. The Federal role in this project unites Canadian dollar efforts in respecting elder health.

Alberta is taking pioneering steps in continuing care with this project to test new and diverse models of care. The project will bring about system change consistent with the vision for the future of continuing care.

This issue of Innovations in Continuing Care will focus

on The Capital Health Authority's Comprehensive Home Option of Integrated Care for Elderly (CHOICE) program and the Cold Lake Health Centre's Maximum Access program. Future issues of the newsletter will profile each of the remaining demonstration projects: native heritage enrichment, and the transitional (short-term) care projects.

New Horizons Directors

... continued from the front panel

Consumer involvement

Another key element of the design of the Demonstration Project includes consumer involvement. As an integral part of the framework of the New Models in Continuing Care Demonstration Project, consumer involvement is provided: in the design at the Steering Committee level; at the level of the proposal design and implementation; and at the level of the project management through the New Horizons Directors.

The New Horizons Directors — who oversee the management of the project and federal contribution funds — ensure that consumers are represented. The Directors are members of the various Committees associated with the

project and ensure that consumers are integral partners in developing new ways of providing continuing care. The consumer values of choice and independence are given full attention in the implementation of the innovative programs. The success of the project depends on the collaboration of partners towards shared goals and the recognition of the unique and valuable contribution of each partner.

Partnerships and consumer involvement ensure that the continuing care system will continue to implement elements of the vision for the future of continuing care. Such changes will make innovative contributions to seniors' independence and quality of life.

Alberta is taking pioneering steps in continuing care with this project to test new and diverse models of care.

Proposed enhancements and recent additions to the program include a comprehensive seniors' wellness clinic and an educational program, collaborative care planning, meals on wheels, wheels to meals, and assisted living.

The Seniors Wellness Program, coupled with an education component, offers seniors and caregivers an opportunity to come to one location to receive services pertaining to the care of the elderly. Clinics are scheduled until April, 1997. Seniors have expressed interest in learning more about sun protection, dental health and life saving, such as suggestions on how to deal with choking.

Collaborative care planning, which is still being developed, would see each client in the community and the continuing care facility

undergoing a comprehensive assessment by an array of health care professionals and family. This will ensure that the client has the opportunity to utilize all available community resources. Then, a collaborative care plan would be developed to meet the needs of the client.

Collaborative care includes the offering of meals on wheels and meals to wheels, a brand new program where clients drive to the facility to have nutritional meals in a friendly, warm, dining room-like atmosphere.

All of the services and enhancements are being met with support from the various partners involved in the initiatives: clients, their families, staff, other caregivers, and administrators. Indeed, the success of the various components of Maximum Access depends on the commitment of all involved, and

a willingness to be flexible in the type of care provided. To ensure that the services and enhancements are on track, regular meetings that include all partners are held, and evaluation tools are used also.

Seniors have indicated their support for Maximum Access and say they prefer the concept of one-stop shopping for their health needs. In the past, they have expressed confusion about the role of health care agencies and identified a lack of care and/or access to care for well seniors. Maximum Access is dealing with these concerns, and the existence of the program itself is a solution. Seniors are also keen on focusing on wellness and efforts to maintain their independence.

Information about this demonstration project, including factors that are critical in making the program work, and indicators of success, can be obtained by contacting:

Barbara Gregoire, Area Four Manager, Lakeland Regional Health Authority, c/o Cold Lake Health Centre, 314 – 25 Street, Cold Lake, Alberta, T0V 0V1.
Phone: (403) 639-3322;
fax: (403) 639-2255.

Innovations IN CONTINUING CARE

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Phone: 403-427-7128 • Fax: 403-427-0767 or
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